

SECOND REGULAR SESSION

HOUSE BILL NO. 1901

97TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES TORPEY (Sponsor), BARNES, GRISAMORE, HAMPTON,
HIGDON, MOLENDORP AND WALKER (Co-sponsors).

5234H.02I

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 208.151, 208.990, and 208.991, RSMo, and to enact in lieu thereof twelve new sections relating to health care coverage, with penalty provisions.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 208.151, 208.990, and 208.991, RSMo, are repealed and twelve new sections enacted in lieu thereof, to be known as sections 191.870, 208.151, 208.186, 208.661, 208.662, 208.990, 208.991, 208.997, 208.998, 208.999, 208.1000, and 208.1001, to read as follows:

191.870. 1. For purposes of this section, the following terms shall mean:

(1) “Enrollee”, shall have the same meaning ascribed to it in section 376.1350;

(2) “Health care provider”, shall have the same meaning ascribed to it in section 376.1350;

(3) “Health care service”, shall have the same meaning ascribed to it in section 376.1350;

(4) “Health carrier”, shall have the same meaning ascribed to it in section 376.1350.

2. Upon request from a patient, potential patient, or such person’s parent or legal guardian, a health care provider shall provide an estimated cost for a health care service based on the patient’s or potential patient’s health benefit plan coverage, Medicaid coverage, Medicare coverage, or uninsured status. If covered by a health benefit plan, Medicaid, or Medicare, the health care provider shall provide the contractual reimbursement rate for the service and, if applicable, the amount the patient or potential patient would pay as a result of a deductible, coinsurance, or co-payment. If a patient or

EXPLANATION — Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

15 potential patient is uninsured, the health care provider shall provide the estimated out-of-
16 pocket cost and information regarding any payment plan or other financial assistance that
17 may be available.

18 3. Health care providers providing estimated costs under subsection 1 of this
19 section shall include with any price quote the following statement:

20 “Your estimated cost is based on the information entered and assumptions about
21 typical utilization and costs. The actual amount billed to you may be different from the
22 estimate of costs provided to you. Many factors affect the actual bill you will receive and
23 this estimate of costs does not account for all of them. Additionally, the estimate of costs
24 is not a guarantee of insurance coverage. You will be billed at the provider’s charge for
25 any service provided to you that is not a covered benefit under your plan. Please check
26 with your insurance company if you need help understanding your benefits for the service
27 chosen.”.

28 4. No provision in a contract entered into, amended, or renewed on or after August
29 28, 2014, between a health carrier and a health care provider shall be enforceable if such
30 contractual provision prohibits, conditions, or in any way restricts any party to such
31 contract from disclosing to an enrollee, patient, potential patient, or such person’s parent
32 or legal guardian the contractual reimbursement rate for a health care service if such
33 payment amount is less than the health care provider’s usual charge for the health care
34 service and if such contractual provision prevents the determination of the potential out-of-
35 pocket cost for the health care service by the enrollee, patient, potential patient, parent, or
36 legal guardian.

37 5. Any violation of the provisions of this section shall result in a fine not to exceed
38 one thousand dollars for each instance of violation.

208.151. 1. Medical assistance on behalf of needy persons shall be known as "MO
2 HealthNet". For the purpose of paying MO HealthNet benefits and to comply with Title XIX,
3 Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301,
4 et seq.) as amended, the following needy persons shall be eligible to receive MO HealthNet
5 benefits to the extent and in the manner hereinafter provided:

6 (1) All participants receiving state supplemental payments for the aged, blind and
7 disabled;

8 (2) All participants receiving aid to families with dependent children benefits, including
9 all persons under nineteen years of age who would be classified as dependent children except for
10 the requirements of subdivision (1) of subsection 1 of section 208.040. Participants eligible
11 under this subdivision who are participating in drug court, as defined in section 478.001, shall
12 have their eligibility automatically extended sixty days from the time their dependent child is

13 removed from the custody of the participant, subject to approval of the Centers for Medicare and
14 Medicaid Services;

15 (3) All participants receiving blind pension benefits;

16 (4) All persons who would be determined to be eligible for old age assistance benefits,
17 permanent and total disability benefits, or aid to the blind benefits under the eligibility standards
18 in effect December 31, 1973, or less restrictive standards as established by rule of the family
19 support division, who are sixty-five years of age or over and are patients in state institutions for
20 mental diseases or tuberculosis;

21 (5) All persons under the age of twenty-one years who would be eligible for aid to
22 families with dependent children except for the requirements of subdivision (2) of subsection 1
23 of section 208.040, and who are residing in an intermediate care facility, or receiving active
24 treatment as inpatients in psychiatric facilities or programs, as defined in 42 U.S.C. 1396d, as
25 amended;

26 (6) All persons under the age of twenty-one years who would be eligible for aid to
27 families with dependent children benefits except for the requirement of deprivation of parental
28 support as provided for in subdivision (2) of subsection 1 of section 208.040;

29 (7) All persons eligible to receive nursing care benefits;

30 (8) All participants receiving family foster home or nonprofit private child-care
31 institution care, subsidized adoption benefits and parental school care wherein state funds are
32 used as partial or full payment for such care;

33 (9) All persons who were participants receiving old age assistance benefits, aid to the
34 permanently and totally disabled, or aid to the blind benefits on December 31, 1973, and who
35 continue to meet the eligibility requirements, except income, for these assistance categories, but
36 who are no longer receiving such benefits because of the implementation of Title XVI of the
37 federal Social Security Act, as amended;

38 (10) Pregnant women who meet the requirements for aid to families with dependent
39 children, except for the existence of a dependent child in the home;

40 (11) Pregnant women who meet the requirements for aid to families with dependent
41 children, except for the existence of a dependent child who is deprived of parental support as
42 provided for in subdivision (2) of subsection 1 of section 208.040;

43 (12) Pregnant women or infants under one year of age, or both, whose family income
44 does not exceed an income eligibility standard equal to one hundred eighty-five percent of the
45 federal poverty level as established and amended by the federal Department of Health and
46 Human Services, or its successor agency;

47 (13) Children who have attained one year of age but have not attained six years of age
48 who are eligible for medical assistance under 6401 of P.L. 101-239 (Omnibus Budget

49 Reconciliation Act of 1989). The family support division shall use an income eligibility standard
50 equal to one hundred thirty-three percent of the federal poverty level established by the
51 Department of Health and Human Services, or its successor agency;

52 (14) Children who have attained six years of age but have not attained nineteen years of
53 age. For children who have attained six years of age but have not attained nineteen years of age,
54 the family support division shall use an income assessment methodology which provides for
55 eligibility when family income is equal to or less than equal to one hundred percent of the federal
56 poverty level established by the Department of Health and Human Services, or its successor
57 agency. As necessary to provide MO HealthNet coverage under this subdivision, the department
58 of social services may revise the state MO HealthNet plan to extend coverage under 42 U.S.C.
59 1396a (a)(10)(A)(i)(III) to children who have attained six years of age but have not attained
60 nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. 1396d using
61 a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r)
62 of 42 U.S.C. 1396a;

63 (15) The family support division shall not establish a resource eligibility standard in
64 assessing eligibility for persons under subdivision (12), (13) or (14) of this subsection. The MO
65 HealthNet division shall define the amount and scope of benefits which are available to
66 individuals eligible under each of the subdivisions (12), (13), and (14) of this subsection, in
67 accordance with the requirements of federal law and regulations promulgated thereunder;

68 (16) Notwithstanding any other provisions of law to the contrary, ambulatory prenatal
69 care shall be made available to pregnant women during a period of presumptive eligibility
70 pursuant to 42 U.S.C. Section 1396r-1, as amended;

71 (17) A child born to a woman eligible for and receiving MO HealthNet benefits under
72 this section on the date of the child's birth shall be deemed to have applied for MO HealthNet
73 benefits and to have been found eligible for such assistance under such plan on the date of such
74 birth and to remain eligible for such assistance for a period of time determined in accordance
75 with applicable federal and state law and regulations so long as the child is a member of the
76 woman's household and either the woman remains eligible for such assistance or for children
77 born on or after January 1, 1991, the woman would remain eligible for such assistance if she
78 were still pregnant. Upon notification of such child's birth, the family support division shall
79 assign a MO HealthNet eligibility identification number to the child so that claims may be
80 submitted and paid under such child's identification number;

81 (18) Pregnant women and children eligible for MO HealthNet benefits pursuant to
82 subdivision (12), (13) or (14) of this subsection shall not as a condition of eligibility for MO
83 HealthNet benefits be required to apply for aid to families with dependent children. The family
84 support division shall utilize an application for eligibility for such persons which eliminates

85 information requirements other than those necessary to apply for MO HealthNet benefits. The
86 division shall provide such application forms to applicants whose preliminary income
87 information indicates that they are ineligible for aid to families with dependent children.
88 Applicants for MO HealthNet benefits under subdivision (12), (13) or (14) of this subsection
89 shall be informed of the aid to families with dependent children program and that they are
90 entitled to apply for such benefits. Any forms utilized by the family support division for
91 assessing eligibility under this chapter shall be as simple as practicable;

92 (19) Subject to appropriations necessary to recruit and train such staff, the family support
93 division shall provide one or more full-time, permanent eligibility specialists to process
94 applications for MO HealthNet benefits at the site of a health care provider, if the health care
95 provider requests the placement of such eligibility specialists and reimburses the division for the
96 expenses including but not limited to salaries, benefits, travel, training, telephone, supplies, and
97 equipment of such eligibility specialists. The division may provide a health care provider with
98 a part-time or temporary eligibility specialist at the site of a health care provider if the health care
99 provider requests the placement of such an eligibility specialist and reimburses the division for
100 the expenses, including but not limited to the salary, benefits, travel, training, telephone,
101 supplies, and equipment, of such an eligibility specialist. The division may seek to employ such
102 eligibility specialists who are otherwise qualified for such positions and who are current or
103 former welfare participants. The division may consider training such current or former welfare
104 participants as eligibility specialists for this program;

105 (20) Pregnant women who are eligible for, have applied for and have received MO
106 HealthNet benefits under subdivision (2), (10), (11) or (12) of this subsection shall continue to
107 be considered eligible for all pregnancy-related and postpartum MO HealthNet benefits provided
108 under section 208.152 until the end of the sixty-day period beginning on the last day of their
109 pregnancy;

110 (21) Case management services for pregnant women and young children at risk shall be
111 a covered service. To the greatest extent possible, and in compliance with federal law and
112 regulations, the department of health and senior services shall provide case management services
113 to pregnant women by contract or agreement with the department of social services through local
114 health departments organized under the provisions of chapter 192 or chapter 205 or a city health
115 department operated under a city charter or a combined city-county health department or other
116 department of health and senior services designees. To the greatest extent possible the
117 department of social services and the department of health and senior services shall mutually
118 coordinate all services for pregnant women and children with the crippled children's program,
119 the prevention of intellectual disability and developmental disability program and the prenatal
120 care program administered by the department of health and senior services. The department of

121 social services shall by regulation establish the methodology for reimbursement for case
122 management services provided by the department of health and senior services. For purposes
123 of this section, the term "case management" shall mean those activities of local public health
124 personnel to identify prospective MO HealthNet-eligible high-risk mothers and enroll them in
125 the state's MO HealthNet program, refer them to local physicians or local health departments
126 who provide prenatal care under physician protocol and who participate in the MO HealthNet
127 program for prenatal care and to ensure that said high-risk mothers receive support from all
128 private and public programs for which they are eligible and shall not include involvement in any
129 MO HealthNet prepaid, case-managed programs;

130 (22) By January 1, 1988, the department of social services and the department of health
131 and senior services shall study all significant aspects of presumptive eligibility for pregnant
132 women and submit a joint report on the subject, including projected costs and the time needed
133 for implementation, to the general assembly. The department of social services, at the direction
134 of the general assembly, may implement presumptive eligibility by regulation promulgated
135 pursuant to chapter 207;

136 (23) All participants who would be eligible for aid to families with dependent children
137 benefits except for the requirements of paragraph (d) of subdivision (1) of section 208.150;

138 (24) (a) All persons who would be determined to be eligible for old age assistance
139 benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C.
140 Section 1396a(f), or less restrictive methodologies as contained in the MO HealthNet state plan
141 as of January 1, 2005; except that, on or after July 1, 2005, less restrictive income
142 methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the
143 income limit if authorized by annual appropriation;

144 (b) All persons who would be determined to be eligible for aid to the blind benefits
145 under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section
146 1396a(f), or less restrictive methodologies as contained in the MO HealthNet state plan as of
147 January 1, 2005, except that less restrictive income methodologies, as authorized in 42 U.S.C.
148 Section 1396a(r)(2), shall be used to raise the income limit to one hundred percent of the federal
149 poverty level;

150 (c) All persons who would be determined to be eligible for permanent and total disability
151 benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C.
152 1396a(f); or less restrictive methodologies as contained in the MO HealthNet state plan as of
153 January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as
154 authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if
155 authorized by annual appropriations. Eligibility standards for permanent and total disability
156 benefits shall not be limited by age;

(25) Persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage pursuant to 42 U.S.C. 1396a (a)(10)(A)(ii)(XVIII). Such persons shall be eligible during a period of presumptive eligibility in accordance with 42 U.S.C. 1396r-1;

(26) Effective August 28, 2013, persons who are in foster care under the responsibility of the state of Missouri on the date such persons attain the age of eighteen years, or at any time during the thirty-day period preceding their eighteenth birthday, without regard to income or assets, if such persons:

(a) Are under twenty-six years of age;

(b) Are not eligible for coverage under another mandatory coverage group; and

(c) Were covered by Medicaid while they were in foster care.

2. Rules and regulations to implement this section shall be promulgated in accordance with chapter 536. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2002, shall be invalid and void.

3. After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to 42 U.S.C. 601, et seq., as amended, in at least three of the last six months immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for MO HealthNet benefits for four calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of income and resource limitation. After April 1, 1990, any family receiving aid pursuant to 42 U.S.C. 601, et seq., as amended, in at least three of the six months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of employment or income from employment of the caretaker relative, shall remain eligible for MO HealthNet benefits for six calendar months following the month of such ineligibility as long as such family includes a child as provided in 42 U.S.C. 1396r-6. Each family which has received such medical assistance during the entire six-month period described in this section and which meets reporting requirements and income tests established by the division and continues to include a child as provided in 42 U.S.C. 1396r-6 shall receive MO HealthNet benefits without fee for an additional six months. The MO HealthNet division may provide by rule and as authorized by annual appropriation the scope of MO HealthNet coverage to be granted to such families.

193 4. When any individual has been determined to be eligible for MO HealthNet benefits,
194 such medical assistance will be made available to him or her for care and services furnished in
195 or after the third month before the month in which he made application for such assistance if
196 such individual was, or upon application would have been, eligible for such assistance at the time
197 such care and services were furnished; provided, further, that such medical expenses remain
198 unpaid.

199 5. The department of social services may apply to the federal Department of Health and
200 Human Services for a MO HealthNet waiver amendment to the Section 1115 demonstration
201 waiver or for any additional MO HealthNet waivers necessary not to exceed one million dollars
202 in additional costs to the state, unless subject to appropriation or directed by statute, but in no
203 event shall such waiver applications or amendments seek to waive the services of a rural health
204 clinic or a federally qualified health center as defined in 42 U.S.C. 1396d(l)(1) and (2) or the
205 payment requirements for such clinics and centers as provided in 42 U.S.C. 1396a(a)(15) and
206 1396a(bb) unless such waiver application is approved by the oversight committee created in
207 section 208.955. A request for such a waiver so submitted shall only become effective by
208 executive order not sooner than ninety days after the final adjournment of the session of the
209 general assembly to which it is submitted, unless it is disapproved within sixty days of its
210 submission to a regular session by a senate or house resolution adopted by a majority vote of the
211 respective elected members thereof, unless the request for such a waiver is made subject to
212 appropriation or directed by statute.

213 6. Notwithstanding any other provision of law to the contrary, in any given fiscal year,
214 any persons made eligible for MO HealthNet benefits under subdivisions (1) to (22) of
215 subsection 1 of this section shall only be eligible if annual appropriations are made for such
216 eligibility. This subsection shall not apply to classes of individuals listed in 42 U.S.C. Section
217 1396a(a)(10)(A)(i).

218 **7. The department of social services shall notify any potential exchange-eligible**
219 **participant who may be eligible for services due to spenddown that the participant may**
220 **qualify for more cost-effective private insurance and premium tax credits under Section**
221 **36B of the Internal Revenue Code of 1986, as amended, available through the purchase of**
222 **a health insurance plan in a health care exchange, whether federally facilitated, state**
223 **based, or operated on a partnership basis and the benefits potentially covered under such**
224 **insurance.**

208.186. 1. Any person participating in the MO HealthNet program who has pled
2 **guilty to or been found guilty of a crime or in a juvenile case admitted to allegations or had**
3 **allegations found to be true involving alcohol or a controlled substance or any crime in**
4 **which alcohol or substance abuse was, in the opinion of the court, a contributing factor to**

5 the person's commission of the crime shall be required to obtain an assessment by a
6 treatment provider approved by the department of mental health to determine the need for
7 services. Recommendations of the treatment provider may be used by the court in
8 sentencing or rendering of a disposition.

9 2. Any person participating in the MO HealthNet program who is a parent or
10 guardian of a child subject to proceedings in juvenile court under subsection 1 or 2 of
11 section 211.031, whose misuse of controlled substances or alcohol is found to be a
12 significant, contributing factor to the reason the child was adjudicated shall be required
13 to obtain an assessment by a treatment provider approved by the department of mental
14 health to determine the need for services. Recommendations of the treatment provider
15 shall be included in the child's juvenile court record. The court may order the parent or
16 guardian to successfully complete treatment before the child is reunified with the parent
17 or guardian.

18 3. The MO HealthNet division shall certify a MO HealthNet participant's
19 enrollment in MO HealthNet if requested by the court under this section. A letter signed
20 by the director of the MO HealthNet division, his or her designee, or the family support
21 division certifying that the individual is a participant in the MO HealthNet program shall
22 be prima facie evidence of such participation and shall be admissible into evidence without
23 further foundation for that purpose. The letter may specify additional information such
24 as anticipated dates of coverage as may be deemed necessary by the department of social
25 services.

208.661. 1. The department of social services shall develop incentive programs,
2 submit state plan amendments, and apply for necessary waivers to permit rural health
3 clinics, federally-qualified health centers, or other primary care practices to co-locate on
4 the property of public elementary and secondary schools with seventy-five percent or more
5 students who are eligible for free or reduced price lunch.

6 2. Any co-location under this section shall require the consent of the school district
7 in the form of a written agreement with the service provider, approved at a public meeting
8 under chapter 610.

9 3. The school district may limit who is eligible to receive services under this section
10 to any one or combination of the following: students, siblings of students, parents or
11 guardians of students, and employees.

12 4. No school-based health care clinic established under this section shall perform
13 or refer for abortion services or provide or refer for contraceptive drugs or devices,
14 consistent with the provisions of section 167.611.

15 **5. The consent of a parent or legal guardian shall be required before a minor may**
16 **receive health care services under this section except as provided in section 431.056.**

17 **6. The provisions of this section shall be null and void unless and until any waivers**
18 **necessary to the implementation of this section are granted by the federal government,**
19 **including waiver of any requirement that federally-qualified health centers and rural**
20 **health clinics provide or refer for abortion services or contraceptive drugs or devices.**

208.662. 1. There is hereby established within the department of social services the
2 **"Show-Me Healthy Babies Program" as a separate children's health insurance program**
3 **(CHIP) for any low-income unborn child. The program shall be established under the**
4 **authority of Title XXI of the federal Social Security Act, the State Children's Health**
5 **Insurance Program, as amended, and 42 CFR 457.1.**

6 **2. For an unborn child to be enrolled in the show-me healthy babies program, his**
7 **or her mother shall not be eligible for coverage under Title XIX of the federal Social**
8 **Security Act, the Medicaid program as it is administered by the state, and shall not have**
9 **access to affordable employer-subsidized health care insurance or other affordable health**
10 **care coverage that includes coverage for the unborn child. In addition, the unborn child**
11 **shall be in a family with income eligibility of no more than three hundred percent of the**
12 **federal poverty level, or the equivalent modified adjusted gross income, unless the income**
13 **eligibility is set lower by the general assembly through appropriations. In calculating**
14 **family size as it relates to income eligibility, the family shall include, in addition to other**
15 **family members, all unborn children.**

16 **3. Coverage for an unborn child enrolled in the show-me healthy babies program**
17 **shall include all prenatal care and pregnancy-related services that benefit the health of the**
18 **unborn child and that promote healthy labor, delivery, and birth. Coverage need not**
19 **include services that are solely for the benefit of the pregnant mother, that are unrelated**
20 **to maintaining or promoting a healthy pregnancy, or that provide no benefit to the unborn**
21 **child. However, the department may include pregnancy-related assistance as defined in**
22 **42 U.S.C. Section 1397ll.**

23 **4. There shall be no waiting period before an unborn child may be enrolled in the**
24 **show-me healthy babies program. In accordance with the definition of child in 42 CFR**
25 **457.10, coverage shall include the period from conception to birth. The department shall**
26 **develop a presumptive eligibility procedure for enrolling an unborn child, which shall**
27 **include verification of the pregnancy.**

28 **5. Coverage for the child shall continue for up to one year after birth, unless**
29 **otherwise prohibited by law or limited by the general assembly through appropriations.**

30 **6. Pregnancy-related and postpartum coverage for the mother shall begin on the**
31 **day the pregnancy ends and extend through the last day of the month that includes the**
32 **sixtieth day after the pregnancy ends, unless otherwise prohibited by law or limited by the**
33 **general assembly through appropriations. The department may include pregnancy-related**
34 **assistance as defined in 42 U.S.C. 1397ll.**

35 **7. The department may provide coverage for an unborn child enrolled in the show-**
36 **me healthy babies program through:**

37 **(1) Direct coverage whereby the state pays health care providers directly, by**
38 **contracting with a managed care organization, or with a group or individual health**
39 **insurance provider;**

40 **(2) A premium assistance program whereby the state assists in payment of the**
41 **premiums, co-payments, coinsurance, or deductibles for a person who is eligible for health**
42 **coverage through an employer, former employer, labor union, credit union, church,**
43 **spouse, other organization, other individual, or through an individual health insurance**
44 **policy that includes coverage for the unborn child, when such person needs assistance in**
45 **paying such premiums, co-payments, coinsurance, or deductibles;**

46 **(3) A combination of direct coverage when the unborn child is first enrolled and**
47 **premium assistance after the child is born; or**

48 **(4) Any other similar arrangement whereby there:**

49 **(a) Are lower program costs without sacrificing health care coverage for the**
50 **unborn child or the child up to one year after birth;**

51 **(b) Are greater covered services for the unborn child or the child up to one year**
52 **after birth;**

53 **(c) Is also coverage for siblings or other family members, including the unborn**
54 **child's mother, such as by providing pregnancy-related assistance under 42 U.S.C. 1397ll,**
55 **relating to coverage of targeted low-income pregnant women through the children's health**
56 **insurance program (CHIP); or**

57 **(d) Will be an ability for the child to transition more easily to non-government or**
58 **less government-subsidized group or individual health insurance coverage after the child**
59 **is no longer enrolled in the show-me healthy babies program.**

60 **8. The department shall provide information about the show-me healthy babies**
61 **program to maternity homes as defined in section 135.600, pregnancy resource centers as**
62 **defined in section 135.630, and other similar agencies and programs in the state that assist**
63 **unborn children and their mothers. The department shall consider allowing such agencies**
64 **and programs to assist in the enrollment of unborn children in the program and in making**
65 **determinations about presumptive eligibility and verification of the pregnancy.**

66 **9. Within sixty days after the effective date of this section, the department shall**
67 **submit a state plan amendment or seek any necessary waivers from the federal Department**
68 **of Health and Human Services requesting approval for the show-me healthy babies**
69 **program.**

70 **10. At least annually, the department shall prepare and submit a report to the**
71 **governor, the speaker of the house of representatives, and the president pro tempore of the**
72 **senate analyzing and projecting the cost savings and benefits, if any, to the state, counties,**
73 **local communities, school districts, law enforcement agencies, correctional centers, health**
74 **care providers, employers, other public and private entities, and persons by enrolling**
75 **unborn children in the show-me healthy babies program. The analysis and projection of**
76 **cost savings and benefits, if any, may include but need not be limited to:**

77 **(1) The higher federal matching rate for having an unborn child enrolled in the**
78 **show-me healthy babies program versus the lower federal matching rate for a pregnant**
79 **woman being enrolled in MO HealthNet or other federal programs;**

80 **(2) The efficacy in providing services to unborn children through managed care**
81 **organizations, group or individual health insurance providers, premium assistance, or**
82 **through other nontraditional arrangements of providing health care;**

83 **(3) The change in the proportion of unborn children who receive care in the first**
84 **trimester of pregnancy due to a lack of waiting periods, by allowing presumptive eligibility,**
85 **or by removal of other barriers, and any resulting or projected decrease in health problems**
86 **and other problems for unborn children and women throughout pregnancy; at labor,**
87 **delivery, and birth; and during infancy and childhood;**

88 **(4) The change in healthy behaviors by pregnant women, such as the cessation of**
89 **the use of tobacco, alcohol, illicit drugs, or other harmful practices, and any resulting or**
90 **projected short-term and long-term decrease in birth defects; poor motor skills; vision,**
91 **speech, and hearing problems; breathing and respiratory problems; feeding and digestive**
92 **problems; and other physical, mental, educational, and behavioral problems; and**

93 **(5) The change in infant and maternal mortality, pre-term births and low birth**
94 **weight babies, and any resulting or projected decrease in short-term and long-term**
95 **medical and other interventions.**

96 **11. The show-me healthy babies program shall not be deemed an entitlement**
97 **program, but instead shall be subject to a federal allotment or other federal appropriations**
98 **and matching state appropriations.**

99 **12. Nothing in this section shall be construed as obligating the state to continue the**
100 **show-me healthy babies program if the allotment or payments from the federal**

101 government end, are not sufficient for the program to operate, or if the general assembly
102 does not appropriate funds for the program.

103 **13. Nothing in this section shall be construed as expanding MO HealthNet or**
104 **fulfilling a mandate imposed by the federal government on the state.**

208.990. 1. Notwithstanding any other provisions of law to the contrary, to be eligible
2 for MO HealthNet coverage individuals shall meet the eligibility criteria set forth in 42 CFR 435,
3 including but not limited to the requirements that:

4 (1) The individual is a resident of the state of Missouri;

5 (2) The individual has a valid Social Security number;

6 (3) The individual is a citizen of the United States or a qualified alien as described in
7 Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996,
8 8 U.S.C. Section 1641, who has provided satisfactory documentary evidence of qualified alien
9 status which has been verified with the Department of Homeland Security under a declaration
10 required by Section 1137(d) of the Personal Responsibility and Work Opportunity Reconciliation
11 Act of 1996 that the applicant or beneficiary is an alien in a satisfactory immigration status; and

12 (4) An individual claiming eligibility as a pregnant woman shall verify pregnancy.

13 2. Notwithstanding any other provisions of law to the contrary, effective January 1, 2014,
14 the family support division shall conduct an annual redetermination of all MO HealthNet
15 participants' eligibility as provided in 42 CFR 435.916. The department may contract with an
16 administrative service organization to conduct the annual redeterminations if it is cost effective.

17 3. The department, or family support division, shall conduct electronic searches to
18 redetermine eligibility on the basis of income, residency, citizenship, identity and other criteria
19 as described in 42 CFR 435.916 upon availability of federal, state, and commercially available
20 electronic data sources. The department, or family support division, may enter into a contract
21 with a vendor to perform the electronic search of eligibility information not disclosed during the
22 application process and obtain an applicable case management system. The department shall
23 retain final authority over eligibility determinations made during the redetermination process.

24 4. Notwithstanding any other provisions of law to the contrary, applications for MO
25 HealthNet benefits shall be submitted in accordance with the requirements of 42 CFR 435.907
26 and other applicable federal law. The individual shall provide all required information and
27 documentation necessary to make an eligibility determination, resolve discrepancies found
28 during the redetermination process, or for a purpose directly connected to the administration of
29 the medical assistance program.

30 5. Notwithstanding any other provisions of law to the contrary, to be eligible for MO
31 HealthNet coverage under section 208.991, individuals shall meet the eligibility requirements

32 set forth in subsection 1 of this section and all other eligibility criteria set forth in 42 CFR 435
33 and 457, including, but not limited to, the requirements that:

34 (1) The department of social services shall determine the individual's financial eligibility
35 based on projected annual household income and family size for the remainder of the current
36 calendar year;

37 (2) The department of social services shall determine household income for the purpose
38 of determining the modified adjusted gross income by including all available cash support
39 provided by the person claiming such individual as a dependent for tax purposes;

40 (3) The department of social services shall determine a pregnant woman's household size
41 by counting the pregnant woman plus the number of children she is expected to deliver;

42 (4) CHIP-eligible children shall be uninsured, shall not have access to affordable
43 insurance, and their parent shall pay the required premium;

44 (5) An individual claiming eligibility as an uninsured woman shall be uninsured.

45 **6. The MO HealthNet program shall not provide MO HealthNet coverage under**
46 **subsection 4 of section 208.991 to a parent or other caretaker relative living with a**
47 **dependent child unless the child is receiving benefits under the MO HealthNet program,**
48 **the Children's Health Insurance Program (CHIP) under 42 CFR Chapter IV, Subchapter**
49 **D, or otherwise is enrolled in minimum essential coverage as defined in 42 CFR 435.4.**

50 **7. (1) The provisions of subsection 7 of section 208.151, section 208.186, section**
51 **208.661, section 208.662, subsection 6 of section 208.990, subdivisions (1) and (7) of**
52 **subsection 1 of section 208.991, subsections 3 to 12, 14, and 15 of section 208.991, and**
53 **sections 208.997, 208.998, 208.999, 208.1000, and 208.1001 shall be null and void unless and**
54 **until:**

55 (a) Any necessary waivers or state plan amendments have been granted by the
56 federal government to implement the provisions of subsections 6 and 7 of section 208.991
57 and subsection 11 of section 208.998;

58 (b) Eligibility of persons set out in subsection 4 of section 208.991 has been
59 approved by the federal Department of Health and Human Services, has been implemented
60 by the department, and notice has been provided to the revisor of statutes;

61 (c) The federal Department of Health and Human Services grants the required
62 waivers, state plan amendments, and enhanced federal funding rate for persons newly
63 eligible under subsection 4 of section 208.991 whereby the federal government agrees to
64 pay the percentages specified in Section 2001 of PL 111-148, as that section existed on
65 March 23, 2010. The provisions of subsections 4 to 12 of section 208.991 shall not be
66 implemented unless such waivers and enhanced federal funding rates are granted by the
67 federal government;

68 (d) The federal Department of Health and Human Services grants the enhanced
69 federal funding rate for the department to provide coverage for persons under subsection
70 9 of section 208.991;

71 (2) If the federal funds at the disposal of the state shall at any time become less than
72 ninety percent of the funds necessary to cover the cost of benefits provided to MO
73 HealthNet participants eligible for coverage under subsection 4 of section 208.991 or are
74 not appropriated to pay the percentages specified in Section 2001 of Public Law 111-148,
75 as that section existed on March 23, 2010, the provisions listed in subdivision (1) of this
76 subsection shall be null and void. If the director of the department of social services is
77 notified that federal funding will fall below ninety percent of the funds necessary to cover
78 the cost of benefits provided to MO HealthNet participants eligible for coverage under
79 subsection 4 of section 208.991, participants will be notified as soon as practicable that the
80 benefits they receive will terminate on the date that federal funding falls below ninety
81 percent.

 208.991. 1. For purposes of [this section and section 208.990] sections 208.990 to
2 208.998, the following terms mean:

3 (1) "Caretaker relative", a relative of a dependent child by blood, adoption, or
4 marriage with whom the child is living, who assumes primary responsibility for the child's
5 care, which may, but is not required to, be indicated by claiming the child as a tax
6 dependent for federal income tax purposes, and who is one of the following:

7 (a) The child's father, mother, grandfather, grandmother, brother, sister,
8 stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;
9 or

10 (b) The spouse of such parent or relative, even after the marriage is terminated by
11 death or divorce;

12 (2) "Child" or "children", a person or persons who are under nineteen years of age;

13 [(2)] (3) "CHIP-eligible children", children who meet the eligibility standards for
14 Missouri's children's health insurance program as provided in sections 208.631 to 208.658,
15 including paying the premiums required under sections 208.631 to 208.658;

16 [(3)] (4) "Department", the Missouri department of social services, or a division or unit
17 within the department as designated by the department's director;

18 [(4)] (5) "MAGI", the individual's modified adjusted gross income as defined in Section
19 36B(d)(2) of the Internal Revenue Code of 1986, as amended, and:

20 (a) Any foreign earned income or housing costs;

21 (b) Tax-exempt interest received or accrued by the individual; and

22 (c) Tax-exempt Social Security income;

23 [(5)] (6) "MAGI equivalent net income standard", an income eligibility threshold based
24 on modified adjusted gross income that is not less than the income eligibility levels that were in
25 effect prior to the enactment of Public Law 111-148 and Public Law 111-152;

26 **(7) "Medically frail", individuals:**

27 **(a) Described in 42 CFR 438.50(d)(3);**

28 **(b) With disabling mental disorders;**

29 **(c) With chronic substance use disorders;**

30 **(d) With serious and complex medical conditions;**

31 **(e) With a physical, intellectual, or developmental disability that significantly**
32 **impairs their ability to perform one or more activities of daily living; or**

33 **(f) With a disability determination based on Social Security criteria.**

34 2. (1) Effective January 1, 2014, notwithstanding any other provision of law to the
35 contrary, the following individuals shall be eligible for MO HealthNet coverage as provided in
36 this section:

37 (a) Individuals covered by MO HealthNet for families as provided in section 208.145;

38 (b) Individuals covered by transitional MO HealthNet as provided in 42 U.S.C. Section
39 1396r-6;

40 (c) Individuals covered by extended MO HealthNet for families on child support closings
41 as provided in 42 U.S.C. Section 1396r-6;

42 (d) Pregnant women as provided in subdivisions (10), (11), and (12) of subsection 1 of
43 section 208.151;

44 (e) Children under one year of age as provided in subdivision (12) of subsection 1 of
45 section 208.151;

46 (f) Children under six years of age as provided in subdivision (13) of subsection 1 of
47 section 208.151;

48 (g) Children under nineteen years of age as provided in subdivision (14) of subsection
49 1 of section 208.151;

50 (h) CHIP-eligible children; and

51 (i) Uninsured women as provided in section 208.659.

52 (2) Effective January 1, 2014, the department shall determine eligibility for individuals
53 eligible for MO HealthNet under subdivision (1) of this subsection based on the following
54 income eligibility standards, unless and until they are changed:

55 (a) For individuals listed in paragraphs (a), (b), and (c) of subdivision (1) of this
56 subsection, the department shall apply the July 16, 1996, Aid to Families with Dependent
57 Children (AFDC) income standard as converted to the MAGI equivalent net income standard;

58 (b) For individuals listed in paragraphs (f) and (g) of subdivision (1) of this subsection,
59 the department shall apply one hundred thirty-three percent of the federal poverty level converted
60 to the MAGI equivalent net income standard;

61 (c) For individuals listed in paragraph (h) of subdivision (1) of this subsection, the
62 department shall convert the income eligibility standard set forth in section 208.633 to the MAGI
63 equivalent net income standard;

64 (d) For individuals listed in paragraphs (d), (e), and (i) of subdivision (1) of this
65 subsection, the department shall apply one hundred eighty-five percent of the federal poverty
66 level converted to the MAGI equivalent net income standard;

67 (3) Individuals eligible for MO HealthNet under subdivision (1) of this subsection shall
68 receive all applicable benefits under section 208.152.

69 **3. The department shall implement an automated process to ensure applicants**
70 **applying for benefit programs are eligible for such programs. The automated process shall**
71 **be designed to periodically review current beneficiaries to ensure that they remain eligible**
72 **for benefits they are receiving. The system shall check applicant and recipient information**
73 **against multiple sources of information through an automated process.**

74 **4. (1) Effective January 1, 2015, and subject to the receipt of appropriate waivers**
75 **and approval of state plan amendments, individuals who meet the following qualifications**
76 **shall be eligible for alternative benefit plans as set forth in section 208.998, subject to the**
77 **other requirements of this section:**

78 (a) Are nineteen years of age or older and under sixty-five years of age;

79 (b) Are not pregnant;

80 (c) Are not entitled to or enrolled for Medicare benefits under Part A or B of Title
81 XVIII of the Social Security Act;

82 (d) Are not otherwise eligible for and enrolled in mandatory coverage under the
83 MO HealthNet program in accordance with 42 CFR 435, Subpart B; and

84 (e) Have household income that is at or below one hundred thirty-three percent of
85 the federal poverty level for the applicable family size for the applicable year as converted
86 to the MAGI equivalent net income standard except the household income may be reduced
87 by a dollar amount equivalent to five percent of the federal poverty level for the applicable
88 family size as required under 42 U.S.C. Section 1396a(e)(14)(I)(i).

89 (2) The department shall immediately seek any necessary waivers from the federal
90 Department of Health and Human Services to implement the provisions of this subsection.
91 The waivers shall:

92 (a) Promote healthy behavior and reasonable requirements that patients take
93 ownership of their health care by seeking early preventive care in appropriate settings,
94 including no co-payments for preventive care services;

95 (b) Require personal responsibility in the payment of health care by establishing
96 appropriate co-payments based on family income that shall discourage the use of
97 emergency department visits for non-emergent health situations and promote responsible
98 use of other health care services;

99 (c) Promote the adoption of healthier personal habits including limiting tobacco use
100 or behaviors that lead to obesity;

101 (d) Allow recipients to receive an annual cash incentive if federal financial
102 participation is obtained for such an incentive, or a cash equivalent if not, to promote
103 responsible behavior and encourage efficient use of health care services;

104 (e) Allow health plans to offer a health savings account option; and

105 (f) Include a request for an enhanced federal funding rate consistent with
106 subsection 14 of this section for newly eligible participants.

107 (3) If such waivers and enhanced federal funding rate are not granted by the
108 federal government, the provisions of this subsection shall be null and void.

109 5. Except for those individuals who meet the definition of medically frail,
110 individuals eligible for MO HealthNet benefits under subsection 4 of this section shall
111 receive only an alternative benefit plan. The MO HealthNet division of the department of
112 social services shall promulgate regulations to be effective January 1, 2015, that provide
113 an alternative benefit plan that complies with the requirements of federal law and is
114 subject to limitations as established in regulations of the MO HealthNet division.

115 6. The department shall require cost sharing to the maximum extent allowed by law
116 including but not limited to a premium of no less than one percent of the individual's
117 income as converted to the MAGI equivalent net income standard. In order to collect the
118 required cost sharing under this subsection, the department may garnish the individual's
119 state income tax returns.

120 7. The department shall apply for a Section 1115 waiver to require workforce
121 participation of individuals otherwise eligible for MO HealthNet such that eligible
122 individuals who are not elderly, disabled, or medically frail shall provide proof of
123 workforce participation. Individuals who fail to provide proof of workforce participation
124 shall be deemed ineligible.

125 8. The department shall provide premium subsidy and other cost supports for
126 individuals eligible for MO HealthNet under subsections 2 and 4 of this section to enroll

127 in employer-provided health plans or other private health plans based on cost-effective
128 principles determined by the department.

129 9. Effective January 1, 2015, the department shall obtain health care coverage for
130 persons who have an income between one hundred percent and one hundred thirty-three
131 percent of the federal poverty level for the applicable family size, for the applicable year
132 as converted to the MAGI equivalent net income standard, who meet all other
133 requirements of subsection 4 of this section and have not been determined to be medically
134 frail by the department, through a health care exchange operating in this state, whether
135 federally facilitated, state based, or operated on a partnership basis, or an employer. The
136 department shall ensure the participants receive the minimum services required to ensure
137 federal reimbursement at the percentages specified in Section 2001 of Public Law 111-148.
138 The department shall require cost sharing to the maximum extent allowed by law.

139 10. Effective January 1, 2015, all persons who have an income up to one hundred
140 thirty-three percent of the federal poverty level for the applicable family size, for the
141 applicable year as converted to the MAGI equivalent net income standard, who are eligible
142 for MO HealthNet benefits under subsection 4 of this section who meet the definition of
143 medically frail shall receive all benefits they are eligible to receive under sections 208.152,
144 208.900, 208.903, 208.909, and 208.930.

145 11. The department shall establish a screening process in conjunction with the
146 department of mental health and the department of health and senior services for
147 determining whether an individual is medically frail and shall enroll all eligible individuals
148 who meet the definition of medically frail and whose care management would benefit from
149 being assigned a health home in the health home program or other care coordination as
150 established by the department. Any eligible individual may opt out of the health home
151 program.

152 12. For individuals who meet the definition of medically frail, the department shall
153 develop an incentive program to promote the adoption of healthier personal habits
154 including limiting tobacco use or behaviors that lead to obesity and for those individuals
155 who utilize the health home program in subsection 11 of this section.

156 13. The department or appropriate divisions of the department shall promulgate rules to
157 implement the provisions of this section. Any rule or portion of a rule, as the term is defined in
158 section 536.010, that is created under the authority delegated in this section shall become
159 effective only if it complies with and is subject to all of the provisions of chapter 536 and, if
160 applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the
161 powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective
162 date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of

163 rulemaking authority and any rule proposed or adopted after August 28, 2013, shall be invalid
164 and void.

165 [4.] **14.** The department shall submit such state plan amendments and waivers to the
166 Centers for Medicare and Medicaid Services of the federal Department of Health and Human
167 Services as the department determines are necessary to implement the provisions of this section.
168 **The department shall request of the federal government an enhanced federal funding rate**
169 **for persons newly eligible under subsection 4 of this section whereby the federal**
170 **government agrees to pay the percentages specified in Section 2001 of PL 111-148, as that**
171 **section existed on March 23, 2010. The provisions of subsections 4 to 12 of this section**
172 **shall not be implemented unless such waivers and enhanced federal funding rates are**
173 **granted by the federal government.**

174 **15.** If at any time the director receives notice that the federal funds at the disposal
175 of the state for payments of money benefits to or on behalf of any persons under subsection
176 4 of this section shall at any time become less than ninety percent of the funds necessary
177 to cover the cost of benefits provided to MO HealthNet participants eligible for coverage
178 under subsections 4, 5, 8, 9, 10, and 12 of this section or are not appropriated to pay the
179 percentages specified in Section 2001 of Public Law 111-148, as that section existed on
180 March 23, 2010, subsections 4 to 12 of this section shall no longer be effective for the
181 individuals whose benefits are no longer matchable at the specified percentages. The date
182 benefits cease shall be stated in a notice sent to the affected individuals.

208.997. 1. The MO HealthNet division shall develop and implement the "Health
2 Care Homes Program" as a provider-directed care coordination program for MO
3 HealthNet recipients who are not enrolled in a prepaid MO HealthNet benefits option and
4 who are receiving services on a fee-for-service basis or are otherwise identified by the
5 department. The health care homes program shall provide payment to primary care
6 clinics, community mental health centers, and other appropriate providers for care
7 coordination for individuals who are deemed medically frail. Clinics shall meet certain
8 criteria, including but not limited to the following:

- 9 (1) The capacity to develop care plans;
10 (2) A dedicated care coordinator;
11 (3) An adequate number of clients, evaluation mechanisms, and quality
12 improvement processes to qualify for reimbursement; and
13 (4) The capability to maintain and use a disease registry.

14 **2.** For purposes of this section, "primary care clinic" means a medical clinic
15 designated as the patient's first point of contact for medical care, available twenty-four
16 hours a day, seven days a week, that provides or arranges the patient's comprehensive

17 health care needs and provides overall integration, coordination, and continuity over time
18 and referrals for specialty care.

19 3. The department may designate that the health care homes program be
20 administered through an organization with a statewide primary care presence, experience
21 with Medicaid population health management, and an established health care homes
22 outcomes monitoring and improvement system.

23 4. This section shall be implemented in such a way that it does not conflict with
24 federal requirements for health care home participation by MO HealthNet participants.

25 5. The department or appropriate divisions of the department may promulgate
26 rules to implement the provisions of this section. Any rule or portion of a rule, as that term
27 is defined in section 536.010, that is created under the authority delegated in this section
28 shall become effective only if it complies with and is subject to all of the provisions of
29 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
30 nonseverable and if any of the powers vested with the general assembly under chapter 536
31 to review, to delay the effective date, or to disapprove and annul a rule are subsequently
32 held unconstitutional, then the grant of rulemaking authority and any rule proposed or
33 adopted after August 28, 2014, shall be invalid and void.

34 6. Nothing in this section shall be construed to limit the department's ability to
35 create health care homes for participants in a managed care plan.

208.998. 1. Except for individuals who meet the definition of medically frail,
2 individuals who qualify for coverage under subsections 2 and 4 of section 208.991 shall
3 receive covered services through health plans offered by managed care entities which are
4 authorized by the department. Health plans authorized by the department:

5 (1) Shall resemble commercially available health plans while complying with
6 federal Medicaid requirements as authorized by federal law or through a federal waiver
7 and may include accountable care organizations, administrative service organizations, and
8 managed care organizations paid on a capitated basis;

9 (2) Shall promote, to the greatest extent possible, the opportunity for children and
10 their parents to be covered under the same plan;

11 (3) Shall offer plans statewide;

12 (4) Shall include cost sharing for outpatient services to the maximum extent allowed
13 by federal law;

14 (5) May include other co-payments and provide incentives that encourage and
15 reward the prudent use of the health benefit provided;

16 (6) Shall encourage access to care through provider rates that include pay-for-
17 performance and are comparable to commercial rates. The department of social services

18 shall determine pay-for-performance provisions that managed care organizations shall
19 execute and shall provide incentives for managed care organizations that perform well;

20 (7) Shall provide incentives, including shared risk and savings, to health plans and
21 providers to encourage cost-effective delivery of care;

22 (8) Shall provide incentive programs for participants to encourage healthy
23 behaviors and promote the adoption of healthier personal habits including limiting tobacco
24 use or behaviors that lead to obesity;

25 (9) May provide multiple plan options and reward participants for choosing a low-
26 cost plan;

27 (10) Shall include the services of community mental health centers; and

28 (11) Shall include the services of health providers as defined in 42 U.S.C. Section
29 1396d(l)(1) and (2) and meet the payment requirements for such health providers as
30 provided in 42 U.S.C. Sections 1396a(a)(15) and 1396a(bb).

31 2. The department may designate that certain health care services be excluded from
32 such health plans if it is determined cost effective by the department.

33 3. (1) The department may accept regional proposals as an additional option for
34 beneficiaries. Such proposals may be submitted by accountable care organizations or other
35 organizations and entities.

36 (2) The department shall advance the development of systems of care for medically
37 complex children who are recipients of MO HealthNet benefits by accepting cost-effective
38 regional proposals from and contracting with appropriate pediatric care networks,
39 pediatric centers for excellence, and medical homes for children to provide MO HealthNet
40 benefits when the department determines it is cost effective to do so. Such entities shall be
41 treated as accountable care organizations.

42 (3) The provisions of subsection 1 of this section shall not apply to this subsection.

43 4. The department shall establish, in collaboration with plans and providers,
44 uniform utilization review protocols to be used by all authorized health plans.

45 5. The department shall establish a competitive bidding process for contracting
46 with managed care plans.

47 (1) The department shall solicit bids only from bidders who offer, or through an
48 associated company offer, an identical or substantially similar plan in services provided
49 and network within a health care exchange in this state, whether federally facilitated, state
50 based, or operated on a partnership basis. The bidder, or the bidder and the associated
51 company, if the bidder has formed a partnership for purposes of its bid, shall include in
52 its bid a process by which MO HealthNet recipients who choose its plan will be
53 automatically enrolled in the corresponding plan offered within the health care exchange

54 if the recipient's income increases resulting in the recipient's ineligibility for MO
55 HealthNet benefits. The bidder also shall include in its bid a process by which an
56 individual enrolled in an identical or substantially similar plan in services provided and
57 network within a health care exchange in this state, whether federally facilitated, state
58 based, or operated on a partnership basis whose income decreases resulting in eligibility
59 for MO HealthNet benefits shall be enrolled in MO HealthNet after an application is
60 received and the participant is determined eligible for MO HealthNet benefits.

61 (2) The department shall select a minimum of two conforming bids and may select
62 up to a maximum number of bids equal to the quotient derived from dividing the total
63 number of participants anticipated by the department in a region by one hundred
64 thousand. For determining accepted bids, the department shall consider the following
65 factors:

66 (a) The cost to Missouri taxpayers;

67 (b) The extent of the network of health care providers offering services within the
68 bidder's plan;

69 (c) Additional services offered to recipients under the bidder's plan;

70 (d) The bidder's history of providing managed care plans for similar populations
71 in Missouri or other states; and

72 (e) Any other criteria the department deems relevant to ensuring MO HealthNet
73 benefits are provided to recipients in such manner as to save taxpayer money and improve
74 health outcomes of recipients.

75 (3) The department shall accept the lowest conforming bid.

76 6. Any managed care organization that enters into a contract with the state to
77 provide managed care plans shall be required to fulfill the terms of the contract and
78 provide such plans for at least twelve months, or longer if the contract so provides. The
79 state shall not increase the reimbursement rate provided to the managed care organization
80 during the contract period above the rate included in the contract. If the managed care
81 organization breaches the contract, the state shall be entitled to bring an action against the
82 managed care organization for any remedy allowed by law or equity and shall also recover
83 any and all damages provided by law, including liquidated damages in an amount
84 determined by the department during the bidding process. Nothing in this subsection shall
85 be construed to preclude the department or the state of Missouri from terminating the
86 contract as specified in the terms of the contract, including for breach of contract, lack of
87 appropriated funds, or exercising any remedies for breach as may be provided in the
88 contract.

89 7. (1) Participants enrolling in managed care plans under this section shall have
90 the ability to choose their plan. In the enrollment process participants shall be provided
91 a list of all plans available ranked by the relative actuarial value of each plan. Each
92 participant shall be informed in the enrollment process that he or she will be eligible to
93 receive a portion of the amount saved by Missouri taxpayers if he or she chooses a lower
94 cost plan offered in his or her region. The portion received by a participant shall be
95 determined by the department according to the department's best judgment as to the
96 portion which will bring the maximum savings to Missouri taxpayers.

97 (2) If a participant fails or refuses to choose a plan as set forth in subdivision (1)
98 of this subsection, the department shall determine rules for auto-assignment, which shall
99 include incentives for low-cost bids and improved health outcomes as determined by the
100 department. Auto-enrolled participants shall be assigned to the highest performing
101 managed care organization.

102 8. This section shall not be construed to require the department to terminate any
103 existing managed care contract or to extend any managed care contract.

104 9. All MO HealthNet plans under this section shall provide coverage for the
105 following services unless they are specifically excluded under subsection 2 of this section
106 and instead are provided by an administrative services organization:

- 107 (1) Ambulatory patient services;
- 108 (2) Emergency services;
- 109 (3) Hospitalization;
- 110 (4) Maternity and newborn care;
- 111 (5) Mental health and substance abuse treatment, including behavioral health
112 treatment;
- 113 (6) Prescription drugs;
- 114 (7) Rehabilitative and habilitative services and devices;
- 115 (8) Laboratory services;
- 116 (9) Preventive and wellness care, and chronic disease management;
- 117 (10) Pediatric services, including oral and vision care; and
- 118 (11) Any other services required by federal law.

119 10. No MO HealthNet plan or program shall provide coverage for an abortion
120 unless a physician certifies in writing to the MO HealthNet agency that, in the physician's
121 professional judgment, the life of the mother would be endangered if the fetus were carried
122 to term.

123 11. The MO HealthNet program shall require managed care plans under this
124 section to provide a high deductible health plan option for uninsured adults nineteen years

of age or older and under sixty-five years of age with incomes of less than one hundred percent of the federal poverty level as converted to the MAGI equivalent net income standard who are enrolled in managed care plans under this section. The high deductible health plan shall include:

(1) A minimum deductible of one thousand dollars and upon meeting the deductible, coverage for benefits as specified by rule of the department;

(2) An account, funded by the department, of at least one thousand dollars per adult to pay medical costs for the initial deductible in the form of a prepaid card;

(3) Preventive care, as defined by the department by rule, that is not subject to the deductible and does not require a payment of moneys from the account described in subdivision (2) of this subsection;

(4) A basic benefits package if annual medical costs exceed one thousand dollars;

(5) Primary care provider visits, as defined by the department by rule, that are not subject to the deductible and do not require a payment of moneys from the account described in subdivision (2) of this subsection;

(6) As soon as practicable, the establishment and maintenance of a record-keeping system for each health care visit or service received by recipients under this subsection. The plan shall require that the recipient's prepaid card number be entered or electronic strip be swiped by the health care provider for purposes of maintaining a record of every health care visit or service received by the recipient from such provider, regardless of any balance on the recipient's card. Such information shall include only the date, provider name, and general description of the visit or service provided. The plan shall maintain a complete history of all health care visits and services for which the recipient's prepaid card is entered or swiped in accordance with this subdivision. If required under the federal Health Insurance Portability and Accountability Act (HIPAA) or other relevant state or federal law or regulation, a recipient shall, as a condition of participation in the prepaid card incentive, be required to provide a written waiver for disclosure of any information required under this subdivision;

(7) The determination of a proportion of the amount left in a participant's account described in subdivision (2) of this subsection at the end of the plan year, which shall be paid to the participant for saving taxpayer money. The amount and method of payment shall be determined by the department; and

(8) The determination of a proportion of a participant's account described in subdivision (2) of this subsection which shall be used to subsidize premiums to facilitate a participant's transition from health coverage under MO HealthNet to private health insurance based on cost-effective principles determined by the department.

12. The department shall require managed care plans under this section to offer an incentive program in which all MO HealthNet participants with chronic conditions, as specified by the department, who are enrolled in managed care plans under this section shall enroll. Participants who obtain specified primary care and preventive services and who participate or refrain from participation in specified activities to improve the overall health of the recipient shall be eligible to receive an annual cash payment if federal financial participation is obtained for such a payment, or a cash equivalent if not, for successful completion of the program. The department shall establish, by rule, the specific primary care and preventive services, activities to be included in the incentive program, and the amount of any annual payments to recipients.

13. A MO HealthNet recipient shall be eligible for participation in only one of either the high deductible health plan under subsection 11 of this section or the incentive program under subsection 12 of this section.

14. No cash payments, incentives, or credits paid to or on behalf of a MO HealthNet participant under a program established by the department under this section shall be deemed to be income to the participant in any means-tested benefit program unless otherwise specifically required by law or rule of the department.

15. Managed care entities shall inform participants who choose the high deductible health plan under subsection 11 of this section that the participant may lose his or her incentive payment under subdivision (7) of subsection 11 of this section if the participant utilizes visits to the emergency department for non-emergent purposes. Such information shall be included on every electronic and paper correspondence between the managed care plan and the participant.

16. The department shall seek all necessary waivers and state plan amendments from the federal Department of Health and Human Services necessary to implement the provisions of this section. The provisions of this section shall not be implemented unless such waivers and state plan amendments are approved. If this section is approved in part by the federal government, the department is authorized to proceed on those sections for which approval has been granted; except that, any increase in eligibility shall be contingent upon the receipt of all necessary waivers and state plan amendments. The provisions of this section shall not be implemented until eligibility of persons set out in subsection 4 of section 208.991 has been approved by the federal Department of Health and Human Services and has been implemented by the department. However, nothing shall prevent the department from expanding managed care for populations under other granted authority.

196 17. The department may promulgate rules to implement the provisions of this
197 section. Any rule or portion of a rule, as the term is defined in section 536.010, that is
198 created under the authority delegated in this section shall become effective only if it
199 complies with and is subject to all of the provisions of chapter 536 and, if applicable,
200 section 536.028. This section and chapter 536 are nonseverable and if any of the powers
201 vested with the general assembly under chapter 536 to review, to delay the effective date
202 or to disapprove and annul a rule are subsequently held unconstitutional, then the grant
203 of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be
204 invalid and void.

 208.999. 1. Managed care organizations shall be required to provide to the
2 department of social services, on at least a yearly basis, and the department of social
3 services shall publicly report within thirty days of receipt, including posting on the
4 department's website, at least the following information:

5 (1) Medical loss ratios for each managed care organization compared with the
6 eighty-five percent medical loss ratio for large group commercial plans under Public Law
7 111-148 and, where applicable, with the state's administrative costs in its fee-for-service
8 MO HealthNet program;

9 (2) Medical loss ratios of each of a managed care organization's capitated
10 specialized subcontractors, such as mental health or dental health, to make sure that the
11 subcontractors' own administrative costs are not erroneously deemed to be expenditures
12 on health care; and

13 (3) Total payments to the managed care organization in any form, including but not
14 limited to tax breaks and capitated payments to participate in MO HealthNet, and total
15 projected state payments for health care for the same population without the managed care
16 organization.

17 2. Managed care organizations shall be required to maintain medical loss ratios of
18 at least eighty-five percent for MO HealthNet operations. If a managed care organization's
19 medical loss ratio falls below eighty-five percent in a given year, the managed care plan
20 shall be required to refund to the state the portion of the capitation rates paid to the
21 managed care plan in the amount equal to the difference between the plan's medical loss
22 ratio and eighty-five percent of the capitated payment to the managed care organization.

23 3. The department of social services shall be required to ensure that managed care
24 organizations establish and maintain adequate provider networks to serve the Medicaid
25 population and to include these standards in its contracts with managed care
26 organizations. Managed care organizations shall be required to establish and maintain
27 health plan provider networks in geographically accessible locations in accordance with

28 travel distances specified by the department of social services in its managed care contracts
29 and as required by the department of insurance, financial institutions and professional
30 registration.

31 4. Managed care plans' networks shall consist of, at minimum, hospitals,
32 physicians, advanced practice nurses, behavioral health providers, community mental
33 health centers, substance abuse providers, dentists, emergent and non-emergent
34 transportation services, federally qualified health centers, rural health centers, women's
35 health specialists, local public health agencies, and all other provider types necessary to
36 ensure sufficient capacity to make available all services in accordance with the service
37 accessibility standards specified by the department of social services.

38 5. Managed care organizations shall be required to post all of their provider
39 networks online and shall regularly update their postings of these networks on a timely
40 basis regarding all changes to provider networks. A provider who is seeing only existing
41 patients under a given managed care plan shall not be so listed.

42 6. The department of social services shall be required to contract with an
43 independent organization that does not contract or consult with managed care plans or
44 insurers to conduct secret shopper surveys of Medicaid managed care plans for compliance
45 with provider network adequacy standards on a regular basis, to be funded by the
46 managed care organizations out of their administrative budgets. Secret shopper surveys
47 are a quality assurance mechanism under which individuals posing as managed care
48 enrollees will test the availability of timely appointments with providers listed as
49 participating in the network of a given plan for new patients. The testing shall be
50 conducted with various categories of providers, with the specific categories rotated for each
51 survey and with no advance notice provided to the managed care plan. If an attempt to
52 obtain a timely appointment is unsuccessful, the survey records the particular reason for
53 the failure, such as the provider not participating in Medicaid at all, not participating in
54 Medicaid under the plan which listed it and was being tested, or participating under that
55 plan but only for existing patients.

56 7. Inadequacy of provider networks, as determined from the secret shopper surveys
57 or the publication of false or misleading information about the composition of health plan
58 provider networks, may be the basis for contract cancellation or sanctions against the
59 offending managed care organization.

60 8. The provider compensation rates for each category of provider shall also be
61 reported by the managed care organizations to help ascertain whether they are paying
62 enough to engage providers comparable to the number of providers available to

63 commercially insured individuals, as required by federal law, and compared, where
64 applicable, to the state's own provider rates for the same categories of providers.

65 9. Managed care organizations shall be required to ensure sufficient access to out-
66 of-network providers when necessary to meet the health needs of enrollees in accordance
67 with standards developed by the department of social services and included in the managed
68 care contracts.

69 10. Managed care organizations shall be required to provide, on a quarterly basis
70 and for prompt publication, at least the following information related to service utilization,
71 approval, and denial:

72 (1) Service utilization data, including how many of each type of service was
73 requested and delivered, subtotaled by age, race, gender, geographic location, and type of
74 service;

75 (2) Data regarding denials and partial denials by managed care organizations or
76 their subcontractors each month for each category of services provided to Medicaid
77 enrollees. Denials include partial denials whereby a requested service is approved but in
78 a different amount, duration, scope, frequency, or intensity than requested; and

79 (3) Data regarding complaints, grievances, and appeals, including numbers of
80 complaints, grievances, and appeals filed, subtotaled by race, age, gender, geographic
81 location, and type of service, including the timeframe data for hearings and decisions made
82 and the dispositions and resolutions of complaints, grievances, or appeals.

83 11. Managed care organizations shall be required to disclose the following
84 information:

85 (1) Plan disenrollment data by cause, number of months with the particular
86 managed care plan prior to disenrollment, and form of enrollment such as passive
87 enrollment or enrollee election;

88 (2) Quality measurement data including, at minimum, all health plan employer data
89 and information set (HEDIS) measures, early periodic screening, diagnosis, and treatment
90 (EPSDT) screening data, and other appropriate utilization measures;

91 (3) Consumer satisfaction survey data;

92 (4) Enrollee telephone access reports including the number of unduplicated calls by
93 enrollees, average wait time before managed care organization or subcontractor response,
94 busy signal rate, and enrollee telephone call abandonment rate;

95 (5) Data regarding the average cost of care of individuals whose care is reported as
96 having been actively managed by the managed care organization versus the average cost
97 of care of the managed care organization's population generally. For purposes of this
98 section, the phrase "actively managed by the managed care organization" means the

99 managed care organization has actually developed a care plan for the particular individual
100 and is implementing it as opposed to reacting to prior authorization requests as they come
101 in, reviewing usage data, or monitoring doctors with high utilization;

102 (6) Data regarding the number of enrollees whose care is being actively managed
103 by the managed care organization, broken down by whether the individuals are
104 hospitalized, have been hospitalized in the last thirty days, or have not recently been
105 hospitalized;

106 (7) Results of network adequacy reviews including geo-mapping and waiting times,
107 stratified by factors including provider type, geographic location, urban or rural area, any
108 findings of adequacy or inadequacy, and any remedial actions taken. This information
109 shall also include any findings with respect to the accuracy of networks as published by
110 managed care organizations, including providers found to be not participating and not
111 accepting new patients;

112 (8) Provider change data indicating how many enrollees changed their primary care
113 provider by cause, months of enrollment, and form of enrollment such as passive
114 enrollment or enrollee election;

115 (9) Any data related to preventable hospitalizations, hospital-acquired infections,
116 preventable adverse events, and emergency department admissions; and

117 (10) Any additional reported data obtained from the managed care plans which
118 relates to the performance of the plans in terms of cost, quality, access to providers or
119 services, or other measures.

208.1000. Subject to appropriations, the department of social services shall develop
2 incentive programs to encourage the construction and operation of urgent care clinics
3 which operate outside normal business hours and are in or adjoining emergency
4 department facilities which receive a high proportion of patients who are participating in
5 MO HealthNet to the extent that the incentives are eligible for federal matching funds.

208.1001. 1. Notwithstanding any other provision of law to the contrary, beginning
2 July 1, 2015, any MO HealthNet recipient who elects to receive medical coverage through
3 a private health insurance plan instead of through the MO HealthNet program shall be
4 eligible for a private insurance premium subsidy to assist the recipient in paying the costs
5 of such private insurance if it is determined to be cost effective by the department of social
6 services. The subsidy shall be provided on a sliding scale based on income with a
7 graduated reduction in subsidy over a period of time not to exceed two years.

8 2. Nothing in this section shall be construed as being part of a MO HealthNet
9 program, plan, or benefit and this section shall specifically not apply to or impact premium
10 subsidies or other cost supports enrolling MO HealthNet participants in employer-

11 provided health plans, other private health plans, or plans purchased through a health care
12 exchange under subsection 9 of section 208.991.

13 3. The department may promulgate rules to implement the provisions of this
14 section. Any rule or portion of a rule, as that term is defined in section 536.010, that is
15 created under the authority delegated in this section shall become effective only if it
16 complies with and is subject to all of the provisions of chapter 536 and, if applicable,
17 section 536.028. This section and chapter 536 are nonseverable and if any of the powers
18 vested with the general assembly under chapter 536 to review, to delay the effective date,
19 or to disapprove and annul a rule are subsequently held unconstitutional, then the grant
20 of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be
21 invalid and void.

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